American Hospital Association®

Reject Reductions to Payments for Graduate Medical Education

AHA View

The AHA opposes proposals to reduce Medicare funding for graduate medical education (GME). The AHA supports legislation to create at least 15,000 new residency positions and end the 18-year freeze on the number of physician training positions that Medicare funds.

Background

Teaching hospitals fulfill critical social missions, including educating and training future medical professionals, conducting state-of-the-art research, caring for the nation's poor and uninsured, and standing ready to provide highly specialized clinical care to the most severely ill and injured patients. The Medicare program has long recognized its responsibility for funding its share of the direct and indirect costs of training medical professionals. Currently, Medicare makes two payments with an educational label: the direct graduate medical education (DGME) payment and the indirect medical education (IME) payment. In fiscal year (FY) 2012, Medicare paid an estimated $2.8 billion for DGME and $6.8 billion for IME.

- DGME Payments. DGME payments help fund the direct costs of operating residency programs, such as resident stipends and benefits, faculty salaries and benefits, and administrative overhead expenses such as classroom space. Medicare DGME payments are based on a hospital-specific, per-resident amount that was determined in 1984 and is updated annually for inflation. Medicare makes DGME payments to each hospital based on its Medicare share of total inpatient days. Teaching settings other than hospitals, such as community health centers, also can receive DGME payments. The total number of residents supported by Medicare is capped at 1996 levels.
- IME Payments. IME payments are explicitly made to compensate for the higher patient care costs associated with teaching hospitals, such as treating complex, severely ill patients, residents' "learning by doing" and greater use of emerging technology. Teaching hospitals offer specialized services such as trauma centers and burn units that can contribute to higher patient care costs. The IME payment adjustment is a percentage add-on to a hospital's inpatient prospective payment system payment, and varies based on the intensity of a hospital's teaching programs, as measured by the ratio of residents to hospital beds. The number of residents included in the calculation of the resident-to-bed ratio also is capped at 1996 levels.

Key Priorities

Reject Reductions to Medicare Funding

Some policymakers are advocating for significant reduction in Medicare GME payments to teaching hospitals. For example, the president's FY 2016 budget calls for reducing the IME adjustment by 10 percent, which would cut Medicare medical education payments by approximately $16.3 billion over 10 years and using a portion of the savings to fund the Targeted Support for GME program. The president would use $5.3 billion over 10 years to promote "the goals of higher value health care that reduces long-term costs." The program would

distribute competitive grants to teaching hospitals, children's hospitals and community-based consortia and other health care entities to support training in primary and preventive care.

Other proposals to change GME have focused on altering Medicare's GME financing structure and have either proposed reducing IME payments to hospitals or redistributing them, sometimes to non-hospital entities. A 2010 report from the Medicare Payment Advisory Commission (MedPAC) asserted that IME payments exceed costs and recommended using the "excess" amount for a performance-based payment program that would reward hospitals that meet unspecified educational outcomes and standards. The Commission also recommended that the Department of Health and Human Services study a range of issues, including the optimal number of residency slots needed by specialty. MedPAC did not recommend an increase in the number of residency positions.

In July 2014, an Institute of Medicine (IOM) committee also recommended sweeping changes to Medicare's GME financing structure. The IOM committee recommended phasing out the distinction between DGME and IME in favor of a single GME payment based on a per-resident amount, adjusted geographically. If implemented, the IOM proposal would end the current stable financing mechanism, uncouple Medicare GME payments from Medicare volumes, permit funds designated for teaching hospitals to be paid to other entities that do not treat Medicare patients and create additional government bureaucracies. According to the IOM committee's own projections, in year five of a 10-year phase out of Medicare GME funding, teaching hospitals would experience effectively a 35 percent cut in payment for GME. In addition, the IOM recommended reevaluating and reassessing the need for continued Medicare funding of GME after 10 years.

The AHA opposes proposals to alter the GME financing structure in a way that reduces DGME or IME payments to teaching hospitals. Reductions in Medicare funding for GME would threaten the stable and predictable financing teaching hospitals need to train physicians for evolving health care system needs and would limit the ability of teaching hospitals to offer state-of-the-art clinical and educational experiences.

Increase the Number of Physician Training Positions

The current cap on residency slots was set in the Balanced Budget Act of 1997 and restricts the number of residency slots for which hospitals may receive Medicare DGME funding. A cap also limits the number of residents that hospitals may count in their ratios of residents-to-beds, which affects IME payments.

These limits on the number of Medicare-funded residency training slots constrain the ability of hospitals to train new physicians. This is especially troubling when our nation is facing a critical shortage of physicians. Experts indicate that the nation could face a shortage of as many as 130,000 doctors by 2025. The expansion

of health care coverage is increasing overall demand for physicians and, therefore, is increasing the projected physician shortfall. Recent estimates by the Health Resources and Services Administration show the U.S. will need from 6,400 to 20,200 additional primary care physicians by 2020[i]. The Association of American Medical Colleges predicts a deficit of 45,400 primary care physicians because of coverage expansion by FY 2025[ii]. Physician shortages would hamper national efforts to improve access to care and may result in longer wait times for patients.

Some in Congress support ways to ease the cap on the number of training positions that Medicare will pay for. The AHA supports legislation to create at least 15,000 new residency positions and end the 18-year freeze on the number of physician training positions that Medicare funds.

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[i] Health Resources and Services Administration. (November 2013). Projecting the Supply and Demand for Primary Care Practitioners Through 2020. *http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/primarycare/projectingprimarycare.pdf.*

[ii] Association of American Medical Colleges. (March 2015). The Complexities of Physician Supply and Demand: Projections from 2013 to 2025, Final Report. *https://www.aamc.org/downlod/426242/data/ihsreportdownload.pdf.*